IHA Regional Pharmacy - Health Record Documentation Practice Standard

Section:	**None**	**Origin Date:**	**August 28, 2007**
Number:	**None**	**Reviewed Date:**	**August 28, 2007**
		Revised Date:	**January 10, 2008**

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1.0 PRACTICE STANDARD

Pharmacists must often document clinical recommendations and activities in the permanent health record. Pharmacists should utilize a standardized, consistent approach to health record documentation to ensure the accurate and timely communication of information related to a patient's medication therapy.

2.0 DEFINITIONS AND ABBREVIATIONS

3.0 EQUIPMENT

4.0 PROCEDURE

4.1 **Pharmacist health record documentation in the health record**

Pharmacists may document medication therapy recommendations and clinical pharmacist interventions and activities pertaining to the medication therapy of patients in the permanent health record.

4.2 **Documenting pharmacist medication therapy recommendations**

Medication therapy recommendations that may be documented should be related to the identification and resolution of potential or actual drug-related problems (DRPs). Examples of DRPs may include (but are not limited to) the following:

1. Indication for drug therapy
2. Drug use without indication
3. Suboptimal drug/route
4. Overdose
5. Dose too high
6. Dose too low
7. Adverse drug reaction
8. Drug interaction
9. Patient non-adherence
10. Non-formulary medication

4.3 **Documenting clinical pharmacist interventions or activities**

Clinical pharmacist interventions and activities that may be documented should be related to the optimization of medication therapy for patients. Examples of clinical pharmacist interventions and activities may include (but are not limited to) the following:

1. Best possible medication history (BPMH)
2. Admission medication reconciliation
3. Allergy history (also on the Allergy/ADR Record)
4. Therapeutic drug monitoring (TDM)*
5. IV to PO step-down policies*
6. Therapeutic interchange policies
7. Adverse drug reaction (ADR) reporting
8. Drug information consultation
9. Formal clinical pharmacist consultation*
10. Discharge medication reconciliation
11. Patient education/counselling*
12. Seamless care activities

Health record documentation required

4.4 **Precautions for health record documentation**

As per the CSHP Direct Patient Care Curriculum Module (1997):

1. Do not make diagnostic statements in the health record;
2. Do not make unreasonable recommendations (e.g. laboratory tests not available at your institution);
3. Do not alter another health care providers documentation;
4. Do not alter your documentation, rather add an addendum note to the health-record at a later time as required;
5. Do not use the health-record to criticize other health care providers;
6. Do not add superfluous wording, and use clear and concise language.

4.5 **Location of pharmacist health record documentation**

Pharmacists should document their clinical recommendations and clinical pharmacist interventions and activities in the physician progress notes using either a handwritten or typed note. Alternatively, documentation can be typed into the pharmacy clinical interventions of Meditech as free text, printed, and placed in the physician progress notes. For centres using an electronic health record only, documentation should be typed into the pharmacy clinical interventions of Meditech as free text. Clinical recommendations and clinical pharmacist interventions or activities should not be documented in any other part of the chart, or on temporary “dear doctor” notes that do not remain as a permanent part of the health record.

4.6 **Verbal communication to support pharmacist health record documentation**

Urgent clinical recommendations and related clinical interventions and activities should be discussed directly with other healthcare professionals (physician, pharmacist, nurse, dietician, or physiotherapist) and the patient as appropriate prior to documentation in the health record. Furthermore, health record documentation should not replace verbal communication, which is the most efficient form of communication, and fosters the development of professional relationships.

4.7 **Timing of pharmacist health record documentation**

Health record documentation should be done as soon as possible after the clinical recommendation is made, or the clinical pharmacist interventions or activities are completed.

4.8 **Format of pharmacist health record documentation**

Pharmacist health record documentation should adhere to a standard, consistent format. Health record documentation should include several essential elements that include (but may not be limited to) the following:

Date and time
Title: “Clinical Pharmacist Note”
ID: Patient age, weight, height, ideal body weight (IBW), or dosing body weight (DBW) if applicable
Body: This should follow the “SOAP” format (see item 4.8)
Closing: Printed name, degree(s), signature, contact telephone or pager.

4.9 **Description of “SOAP” format for pharmacist health record documentation**

The following is a description of the “SOAP” format that should be followed for the body of pharmacist notes documented in the health record. This format should be followed for each drug-related issue identified. Not all of the components below may be available, relevant, or required, but this will depend on the clinical scenario. The examples below are intentionally very complete, but do not contain extraneous information. Shorter notes are appropriate if they provide enough subjective and objective information to support the assessment and recommendation. The length of a note is not a determinant of its quality.

Subjective

Pertinent clinical information (e.g. history, symptoms, previous or current treatments, previous response to therapy, etc.) provided to the pharmacist from the patient. Some patients will not be able to provide this information due to a language barrier or due to the severity of their injuries. In these cases, this section can be left out of the note.

Objective
Pertinent objective information relevant to the drug-related issue. This section should follow the order of:

Vitals: (Temperature, blood pressure, heart rate, respiratory rate)

Physical exam findings:
Pertinent findings documented from the chart, or obtained from an MD, RN, or trained pharmacist.
This should be presented by system:

General appearance
CNS (Central nervous system)
HEENT (Head, ears, eyes, nose, throat)
RESP (Respiratory)
CVS (Cardiovascular)
ABD/GU (Abdominal, genitourinary)
MSK/EXTR/SKIN (Musculoskeletal, extremities, skin)

Laboratory data:
Pertinent laboratory data required for the assessment of the problem, or to determine efficacy and toxicity of drug therapy

Microbiological data:
Pertinent gram stain, smear, and culture and susceptibility results (pending or reported), etc.

Diagnostic tests:
Pertinent tests used to diagnose conditions amenable to drug therapy or those used to monitor the efficacy or toxicity of drug therapy (e.g. EEG (electroencephalogram), CT (computed tomography), MRI (magnetic resonance imaging), CXR (chest x-ray), EKG (electrocardiogram), TTE (transthoracic echocardiogram), TEE (transesophageal echocardiogram), CATH (cardiac catheterization), EGD (esophageal gastroduodenoscopy), abdominal flat plate (x-ray), abdominal ultrasound, abdominal CT scan, IVP (intravenous pyelogram), bone scan, DUS (doppler ultrasonography) etc.

Current medication therapy:
Pertinent scheduled or PRN medications relating to the drug-related issue being discussed.

Assessment
This section should include the identification of the specific drug-related problem(s) relating to the drug-related issue being discussed. These

should take the form of DRPs as listed in section #4.2.
An appropriate assessment should also consider the desired goals of therapy (e.g. symptoms, morbidity, mortality, quality of life, pharmacoeconomic goals (e.g. cost-effectiveness). These therapeutic goals should be consistent with the proven benefits of the specific drug therapy based on literature evidence. For many notes, it may not be required to list these goals, unless it is pertinent to the selection amongst available alternative agents.
This section should also discuss reasonable therapeutic alternatives for the drug-related issue being discussed. Choosing between alternatives can be done based on the following factors, and should be based on literature evidence where available:

1. Efficacy
2. Toxicity
3. Cost
4. Patient-specific factors (e.g. allergies, organ function, etc.)
5. Ease of administration

For many notes, it may not be required to list the alternatives in the note, unless it is pertinent to the argument for the recommendation.

Plan
This should clearly outline the direct patient-specific medication therapy recommendation from the clinical pharmacist.

This section should also recommend any pertinent repeat laboratory tests, cultures, etc. as part of your monitoring plan for efficacy or toxicity.

This section should also include a recommendation for when the patient should next be re-evaluated to determine if he/she is meeting his/her drug therapy goals.

4.10 **Content and information included in pharmacist health record documentation**
Pharmacist health record documentation should contain accurate and factual information presented in a clear and concise fashion that is relevant to the patient's care. Only pertinent subjective and objective information required and related to the assessment should be included in the note. Enough information should be included in the note for the reader to understand how the pharmacist arrived at the assessment and plan. The note should not contain jargon or non-standardized abbreviations, and should contain standard SI units of measure.

4.11 **Probationary period for pharmacist health record documentation**
All new staff will be required to discuss and/or draft the content of any health record documentation with the clinical coordinator, professional practice leader, or designate for a 3-month probationary period. At 3

months the supervisor will determine if the pharmacist has successfully adopted and mastered the clinical practice skill of health record documentation to a sufficient degree to practice independently. Any pharmacist can request feedback or assistance with health record documentation from peers, supervisors, or the Clinical Pharmacist Resource (CPR) service at any time if they have questions about the content or format of a note. This feedback should be requested prior to documenting in the health record.

4.12 **Continuous quality improvement procedures for pharmacist health record documentation**

Health record documentation by pharmacists will be audited for content, quality, and appropriateness by supervisory staff. Photocopies or printed duplicates of all notes from all pharmacists in the health record should be forwarded to the clinical coordinator, professional practice leader (or designate) for continuous review, feedback, and suggestions for improvement to the pharmacists. This will enable ongoing peer review and mentorship and ensure a continuous quality improvement process is in place for pharmacist health record documentation and therapeutic decision-making.

5.0 DOCUMENTATION CONSIDERATIONS

The following are examples of pharmacist health record documentation notes using the SOAP format. The content and length of the notes will depend on the complexity of the patient case or clinical scenario, and whether it is an original or follow-up note.

SAMPLE: Therapeutic Drug Monitoring Note

Sept 12/01 (12:00) Clinical Pharmacist Note – Hospital acquired pneumonia

ID: Mrs. Jones is a 50 yo female, Wt = 85 kg, Ht = 172 cm, IBW = 64 kg, aminoglycoside DBW = 72 kg

S: Mrs. Jones states she feels more fatigued today with more fevers and chills, shortness of breath, and “my cough is worse”. She denies any tinnitus, “fullness” in her ears or nausea.

O: Tmax=39.6 (Sept 11th – 38.0), BP=128/70, HR=80, RR=22
MD and RN notes indicate “dullness to percussion”, bronchial breath sounds, and decreased air entry over right lower lobe, with increased production of moderate amounts of mucopurulent yellow-green secretions.
WBC = 16.0 (Sept 11th - 12.5), Scr = 100 umol/L (prev 105), CrCl = 69 ml/min
ABG – 7.45/35/90/24 O_2 sat = 93% on 40% (prev 30%) O_2 via facemask

Sputum (Sept 10th) Gram stain – WBC+2, GNB +2
Culture - *Pseudomonas aeruginosa* (sensitivities pending)
Sputum (Sept 12th) Gram stain – WBC+3, GNB+4
Culture - Pending
CXR - Increasing consolidation over right lower lobe (per chart)

Medications:
Piperacillin/tazobactam 3.375 g IV q6h (day #3)
Tobramycin 120 mg IV q12h (day #3)

Tobramycin serum concentrations drawn around 5th dose today:
Pre = 0.6 mg/L (0730h) *Infusion 0800h-0830h
Post = 5.6 mg/L (0900h)
Extrapolated Cpeak = 6.2 mg/L, Cmin = 0.6 mg/L
Calculated k = 0.202 h^{-1}, $T^{1/2}$ = 3.4 h, Vd = 22.2 L (0.3 L/kg)

A: Empiric double-coverage appropriate for *Pseudomonas aeruginosa*, and all tobramycin doses administered on time. Patient clinically deteriorating, possibly due to low tobramycin peak serum concentrations. No adverse drug reactions noted or suspected on current therapy. Patient is a candidate for high-dose, extended interval aminoglycoside dosing, which should be dosed at 6 mg/kg (DBW) once daily.

P:
1. Suggest changing tobramycin to 440 mg IV q24h to be infused over an hour with the next dose due at 1800h tonight x 7 more days, then reassess.
2. Continue piperacillin/tazobactam 3.375 g IV q6h x 7 more days, then reassess.
3. I will follow-up on sputum C&S tomorrow to confirm sensitivity of organism, and reassess for adequate clinical response after 48-72 hours.
4. Suggest BUN and Scr on Monday and Thursday while on tobramycin.
5. No repeat tobramycin serum concentrations required. If Scr > 120 umol/L (CrCl < 60 ml/min), pharmacist will reassess need for dosing interval extension.

Thank you,
Pharmacist Signature, Printed Name, Designation
Pager or contact phone number

SAMPLE: Dosage Adjustment for Renal Dysfunction

Sept 12/01 (12:00) Clinical Pharmacist Note – Urinary Tract Infection

ID: Mr. Smith is a 80 yo male, Wt = 70 kg, Ht = 172 cm

S: Mr. Smith is feeling better today with less fever, chills, and dysuria. He denies any somnolence, dizziness, twitching, nausea or vomiting. He has not yet started to take a diet, and has not received any oral medications. He mentions he has an underlying history of "some kidney problems".

O: Tmax=38.8 (Sept 11th - 39.5), BP=130/70, HR=70, RR=16
MD notes indicate decreasing costovertebral angle tenderness, urine is more clear, less foul-smelling today, foley catheter still in place.
WBC = 13.0 (Sept 10th -15.0), Scr= 200 umol/L (Sept 10th - 210), CrCl= 27 ml/min
Urinalysis (Sept 9th) – Leukocytes +3, RBC +2, hyaline casts +3
Urine culture (Sept 9th) – *E. coli* sensitive to imipenem, tobramycin, ciprofloxacin

Medications:
Ciprofloxacin 400 mg IV q12h (day #3)
No prn acetaminophen used, no analgesics, dimenhydrinate 50 mg IV x 2 given yesterday for complaints of nausea per chart.

A: Ciprofloxacin appropriate for pyelonephritis from *E. coli*, but the current dose is too high for the patient's renal function. Ciprofloxacin has a concentration-dependent killing characteristics, so the dosing interval should be extended, rather than the dosage reduced. The patient is clinically improving on the current therapy and is not showing any signs or symptoms of dose-related toxicity from ciprofloxacin. As the patient improves, he may be a candidate for IV to PO stepdown.

P: 1. Suggest changing ciprofloxacin to 400 mg IV q24h x 11 more days.
2. I will reassess the patient in 48 hours for possible IV to po conversion.
3. Suggest recheck BUN and Scr in 48-72 hours.

Thank you,
Pharmacist Signature, Printed name, Designation
Pager or contact phone number

SAMPLE: IV to PO stepdown

Sept 14/01 (12:00) Clinical Pharmacist Note – Urinary Tract Infection

ID: Mr. Smith is a 80 yo male, Wt = 70 kg, Ht = 172 cm

S: Mr. Smith is feeling better today with no fever, chills, or dysuria. He is tolerating a full oral diet, and is taking oral acetaminophen as needed for pain. He denies any nausea or vomiting, and has no history of gastrointestinal disorders.

O: Tmax=37.5 (Sept 13th - 38.0), BP=140/70, HR=60, RR=14
MD notes urine is clear, amber, non-odorous, and the foley catheter removed.
WBC = 8.0 (Sept 12th - 13.0), Scr= 190 umol/L (Sept 12th - 200), CrCl= 28 ml/min
Urine culture (Sept 9th) – *E. coli* sensitive to imipenem, tobramycin, ciprofloxacin
Blood culture x 2 sets (Sept 10th) - No growth x 4 days
Ciprofloxacin 400 mg IV q24h (day #5)
Prn acetaminophen 325 mg x 2 doses used for headache, no antiemetics given.

A: Ciprofloxacin appropriate for pyelonephritis from *E. coli*, but the patient is a suitable candidate for IV to PO stepdown of ciprofloxacin.

P: 1. Order written for ciprofloxacin to 500 mg po q24h x 9 more days (to complete a total course of 14 days).
2. I will reassess patient in 48 hours to ensure tolerability of IV to po conversion.

Thank you,
Pharmacist Signature, Printed name, Designation
Pager or contact phone number

SAMPLE: Clinical Pharmacy Consult

Sept 14/01 (14:00) Clinical Pharmacist Note – Pain Control

ID: Mr. Smith is a 40 yo male, Wt = 80 kg, Ht = 172 cm

S: Mr. Smith was in a motor vehicle accident 3 days ago and suffered a broken left leg, broken left arm, and three fractured ribs on his left side. He states he had surgery on Sept 12th on his leg and was complaining about uncontrolled pain this morning, which led to the initiation of a pharmacist consult from the orthopaedic surgeon. Mr. Smith states he was taking no medications prior to admission, and has no history of chronic pain. Currently he describes his pain as a dull ache rated as 8/10, and he had a dose of IM morphine 5 hours ago. The pain is primarily in his ribs and leg, and does not radiate. The pain is present at all times, and the pain is worse after going for long periods without medication, and after ambulation with physiotherapy, and gets as bad as 10/10. At its best, it was down to 4/10 after an IV morphine breakthrough dose. He would like to keep the pain below a 6/10. He does not feel his prn acetaminophen has made any difference to his pain. Mr. Smith complains of somnolence, dry mouth, and mild nausea, 30 minutes after his IM morphine, and feels constipated. He is tolerating oral intake and medications. He has taken NSAIDS in the past with no history of dyspepsia or peptic ulcer disease or renal disease. He has no allergies.

O: Tmax=37.0, BP=150/80, HR=110, RR=24
Patient appears to be in some distress. He is alert, and oriented x 3, pupils equal and reactive to light at 4 mm, dry mucous membranes, furrowed brow, diaphoresis, shallow, rapid breathing, abdomen slightly distended, (+) bowel sounds, no BM in 48 hours (per chart).
Scr = 80 umol/L, est CrCl = 112 ml/min, LFTs – normal, Alb = 40, INR = 0.9

Medications:	Sept 12	Sept 13	Sept 14
Morphine 10 mg IM q6h	30 mg	40 mg	30 mg
Morphine 2 mg IV q2h prn	16 mg	20 mg	22 mg
Morphine parenteral equivalents	46 mg	60 mg	52 mg
Acetaminophen 650 mg po q4h prn	1300 mg	650 mg	1300 mg
No bowel protocol given			

A: Patient suffering from uncontrolled bone and inflammatory post-operative pain, and incidental pain during ambulation with physiotherapy. Although morphine is a suitable treatment option, the current regimen is being given via a suboptimal route and regimen. Oral morphine will have a lower peak concentration and last longer than IM dosing. PRN frequency needs to be shorter to provide rapid pain relief, and pre-medication would help to prevent ambulation-induced pain during physiotherapy. Given inflammatory component to pain, and in the absence of contraindications, an NSAID would be a useful adjunctive therapy.

Acetaminophen has been ineffective and is likely not indicated in this patient at this time. Patient is suffering mild CNS, anticholinergic, and gastrointestinal ADRs at the peak effect of IM morphine. A routine stool softener and stimulant laxative are indicated to prevent opioid-induced constipation in this patient.

P: I would recommend the following:

1. Docusate 100 mg po bid regularly
2. Sennosides – 2 tablets daily at bedtime
3. D/C IM morphine, IV morphine, and acetaminophen orders
4. Morphine 15 mg PO q4h regularly
5. Morphine 2 - 4 mg IV 10 minutes prior to physiotherapy and q 15 minutes prn (maximum dose of 40 mg/24 hours)
6. Ibuprofen 400 mg po q6h regularly with food
7. I will reassess the patient in 24 hours for pain control, constipation and ADRs

Thank you,
Pharmacist Signature, Printed name, Designation
Pager or contact phone number

6.0 SPECIAL CONSIDERATIONS

N/A

7.0 REFERENCES

N/A

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Implementation Plan approved by Pharmacy Managers – Dec 18/07

Keywords: Health record documentation; chart documentation.